



CENTER FOR  
PELVIC HEALTH AND WELLNESS

## **Welcome to the Center for Pelvic Health and Wellness!**

We are dedicated to your total pelvic health and lifelong wellness.

To individualize your care and create a comprehensive treatment and wellness plan for you, we ask you to take time to **FILL OUT our PATIENT FORMS PRIOR to and bring to your first appointment.**

New patient forms are available on our website [www.pelvichealthwellness.com](http://www.pelvichealthwellness.com) and click on forms. You **may also fax them back to us at 949-364-2829 or email them to [info@pelvichealthwellness.com](mailto:info@pelvichealthwellness.com)**. Please make sure to bring your **insurance card and photo ID** with you on your initial appointment.

Please arrive 30 minutes early for your office visit, to allow us to confirm that we have everything we need to get you on your path towards pelvic health and wellness.

### **New Patient Visit**

Your initial visit is comprised of a complete and thorough review and evaluation of your health history and a focused physical exam. Your provider may recommend additional tests before finalizing your comprehensive and integrative plan, including blood work, bladder testing, imaging, and records from past evaluations. If you have copies of past evaluations and treatments, please bring with you to your visit.

### **Lab Tests, Imaging, or Mammograms**

Your provider will provide you with necessary lab or imaging requisition forms. Please take these forms to the contracted facility with your insurance plan. If one has a high insurance deductible, paying cash for services may be more cost effective.

The Center for Pelvic Health and Wellness also has a negotiated cash discount for certain lab panels that include a CBC, Complete Metabolic Panel, Comprehensive Thyroid Panel, Hormones, Vitamin B12, and Vitamin D through Labcorp. If you have any of these lab panels ordered, please tell your provider which you prefer at the time of service. If you choose a cash lab option, we will collect that fee upon your check-out, and the lab will bill us directly.

**Should you have any additional questions please feel free to call 949-364-4400, option 2.**

We are so happy you chose to join us at the Center for Pelvic Health and Wellness!!

Sincerely,

Lisa Andrade, Office Manager



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**DEMOGRAPHICS**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: \_\_\_\_\_ SSN: \_\_\_\_\_

Email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Primary Care Physician (PCP) \_\_\_\_\_ Phone #: \_\_\_\_\_

How did you hear about us (circle): Friend Doctor Internet Social Media Ad Insurance

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Pharmacy Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address, City, Zip: \_\_\_\_\_ Fax #: \_\_\_\_\_

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Responsible Party Other than Patient: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

ASSIGNMENT & RELEASE: I HEREBY AUTHORIZE THE CENTER FOR PELVIC HEALTH AND WELLNESS (INCONTINENCE & PELVIC SUPPORT INSTITUTE-IPSI) TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND IRREVOCABLY ASSIGN TO THE DOCTOR ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO ME OR MY DEPENDENTS. I HEREBY AUTHORIZE IPSI TO ACCESS, COMMUNICATE AND MAINTAIN MY MEDICATION HISTORY ELECTRONICALLY THROUGH ESCRIBE AND/OR OTHER ELECTRONIC PRESCRIPTION SERVICES IN CONNECTION WITH MY MEDICAL TREATMENT AND IN COMPLIANCE WITH IDPAA REGULATIONS.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICIES. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. FOR ANY BALANCES OVER 45 BUSINESS DAYS OUTSTANDING, I UNDERSTAND THERE MAY BE A MONTHLY FEE FOR BILLING SERVICE, PLUS INTEREST. A PHOTOCOPY OR SCANNED COPY OF THIS ASSIGNMENT AND RELEASE IS AS VALID AND EFFECTIVE AS THE ORIGINAL

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Relationship if Minor \_\_\_\_\_



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**RECORD OF DISCLOSURES**

**I prefer to be contacted via:** (Check all that apply):

Cell Phone Number: \_\_\_\_\_

**OK to leave detailed message including clinical information YES or NO**

Home Phone Number: \_\_\_\_\_

**OK to leave detailed message including clinical information YES or NO**

Email: \_\_\_\_\_

**OK to leave detailed message including clinical information YES or NO**

**If available, I agree to receive text message alerts about upcoming appointments:**

**YES or NO**

**I agree to receive Email correspondence about upcoming events, seasonal promotions, new services, announcements, the Center for Pelvic Health and Wellness newsletter, blog, etc.**

I understand that I have the option to opt out at any time.

**YES or NO**

**Private Practice Acknowledgement**

**\*\* NOTE:** A copy of our private practice policy is available upon request.

I have received the Notice of Privacy Practices and I have been provided with an opportunity to review it.

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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**HELPFUL TIPS FOR COMMUNICATION WITH OUR OFFICE**

You and your health are very important to us.  
We understand that it is sometimes hard to navigate the phone system.

**PRIMARY PHONE NUMBER:** (949) 364-4400

**FAX:** (949)364-2829

**ONCE THE GREETING BEGINS SELECT ONE OF THE FOLLOWING EXTENSIONS**

Please leave a message if your party does not answer.

Be sure to leave your full name, date of birth and a phone number where you can be reached.

<b>APPOINTMENT SCHEDULING/RECEPTION</b>	select <b>101</b> or <b>102</b>
<b>MEDICAL ASSISTANT</b> or for <b>REFILLS</b> and <b>TEST RESULTS</b>	select <b>107</b>
<b>SURGERY SCHEDULER – AUTHORIZATION SPECIALIST</b>	select <b>104</b>
<b>MEDICAL RECORD SPECIALIST</b>	select <b>103</b>
<b>MANAGER/ADMINISTRATION (Direct Line 949-365-8845)</b>	select <b>106</b>
<b>BILLING OFFICE</b> dial <b>949-436-0014</b>	

Messages received before **4:30 pm Monday – Thursday** will be returned within **24 hours**. Our office closes **at noon on Fridays**. Messages received before **noon on Friday**, will be returned before the close of the **business day**.

If you require a prescription refill, it is best to call your pharmacy for a refill request to be sent electronically to the office – this often results in faster refills.

**If you are calling after hours for an issue that cannot wait until the next day, please call our answering service at 949-361-3247**

The patient portal is a new way to communicate directly with your provider. Our staff will give you the information to set up your portal account. Portal messages will be answered throughout the day, however, it is important to note **to not send any urgent messages or urgent refill requests through the portal**. Responses to your inquiries will be answered within 2 business days. Portal messages allow for more detailed questions rather than phone messages, but your provider may decide that you need telehealth or in-office visit to completely address your concerns.

**If you are experiencing an emergency, please call 911.**

Thank you for your patience and support!

Drs. Wallace, Kanaly, Horton and Annelise Merriner PA-C